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Thinking about long-term care policies for Latin America

Pensando en políticas de cuidados de larga duración para América Latina

Mauricio Matus-López[1]

[1]*PhD in Economics. Professor, Departamento de Economía, Métodos Cuantitativos e Historia Económica, Universidad Pablo de Olavide, Spain.* ✉

ABSTRACT Latin America is aging. The process is occurring quickly and in unhealthy conditions with low levels of income. The number of older people who can no longer perform their daily activities will dramatically increase in the coming decades. Developed countries have already been facing this phenomenon over the last three decades, but Latin America has neither the resources nor the social protection systems of these countries. Formulating and planning health policies associated with this phenomenon should be a priority of the governments of Latin America. This paper defines what these care policies are, the models of care rich countries have developed, and the cost of such models. The situation in Latin America is then analyzed and conclusions and a series of discussions to address in the near future are proposed.

KEY WORDS Health Public Policy; Long-Term Care; Demographic Aging; Healthcare Financing; Latin America.

RESUMEN América Latina envejece. Lo hace muy rápido, en condiciones poco saludables y con bajos niveles de ingreso. En las próximas décadas aumentará vertiginosamente el número de personas mayores que no podrán realizar las actividades de su vida diaria por sí mismas. Este fenómeno ya lo han enfrentado los países ricos en las últimas tres décadas pero, a diferencia de ellos, la región no dispone ni de los recursos ni de los sistemas de protección social de esos países. Pensar y planificar políticas de salud asociadas a este fenómeno debería ser una prioridad de los gobiernos latinoamericanos. En el presente trabajo se define en qué consisten estos cuidados, qué modelos han desarrollado los países ricos y a qué costo. Posteriormente se analiza la situación de América Latina y se propone una serie de discusiones para abordar en el futuro cercano.

PALABRAS CLAVES Políticas Públicas de Salud; Cuidados a Largo Plazo; Envejecimiento de la Población; Financiación de la Atención de la Salud; América Latina.

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INTRODUCTION

What is long-term care? Where is long-term care provided? Should Latin America start considering having care policies? These are a few questions this article seeks to address.

At present, only thirty countries have long-term care (LTC) policies. All these countries are members of the Organization for Economic Co-operation and Development (OECD) and most of them belong to the European Union (EU). However, Chile, for example, is part of the OECD and does not have these policies, and Romania belongs to the EU and does not have them either.

Before the nineties, only a few number of countries had a formal long-term care system. In the mid-nineties almost all of the systems in place at present appeared, like in Germany and France, and the systems in place at those times were reformed, like in Norway and Denmark. So far this century, new models have been incorporated, like in Portugal and Spain, and reforms were introduced and parliamentary discussions were held again in countries like the US and the United Kingdom. In the recent years, more than two thirds of these countries have reformed aspects related to the use of the services and more than half of these countries have introduced reforms in costs and financing.[1]

This dynamic shows long-term care continues to be a relevant and current issue. The classifications used just over a decade ago, based on Welfare States, have become obsolete for many countries. Long-term care policies in Nordic countries were classified as *Beveridge* models, with a wide public coverage and provision, whereas in the Mediterranean countries long-term care policies were defined as "social assistance" policies, with a limited coverage and a marked private spending. In the middle of these two classifications appeared the *Bismarck* models, which were closer to Nordic models than to Mediterranean models.[2] Today, this strictly compartmentalized classification seems to be rather inappropriate. In addition to the fact that at present not only the European countries have a formal model, the Mediterranean countries are increasingly much closer to continental countries, and Nordic countries have modified their systems by incorporating private management and funding.

All indicators show that in the next few years Latin America will face the same aging problem the countries above have faced in the past. Regional studies are progressively taking shape, and to this end, it can be of great use to analyze the experiences collected by the existing models and the reforms they have introduced.

This paper defines the concept of long-term care and its services, and it includes a brief description of the models from four different points of view: the relationship with informality, coverage of the services, type of financial aid and the cost of each model. Based on these four points of view, it is discussed if there are models whose evidence allows them to be classified as more efficient than others; that is to say, models with good results and low costs. In a penultimate section, there is a recent review of the state of art in Latin America, followed by a final section where conclusions are presented.

METHODOLOGY

The methodology used in this paper includes two different parts: the first part is a bibliographic revision made up of academic articles and documents issued by international organizations, and the second part deals with statistics.

To describe the existing models in place around the world, the bibliography has been selected based on four criteria: firstly, the articles had to be indexed in the databases of PubMed, Web of Science or Scopus; secondly, these articles had to be articles which were published from 2009 onward; thirdly, the articles had to address international comparisons; and, fourthly these articles had to be relevant to the aims of this paper. To recover these documents, the following terms were used: long-term care, health policy, international comparison, long-term care services, institutional care, residential care, home-based care and cash-for-care. In the case of Latin America, the results were not enough so the research study was extended until 2005 and the topic was widened into aging and health ("aging" and "health" and "Latin America").

The selected public reports explicitly defined and described long-term care for a set of countries which had models in use at those times, like the member countries of the OECD and the EU, and were published from 2009 onward. For Latin America, documents issued by the World Bank (WB), the Pan American Health Organization

SALUD COLECTIVA. 2015;11(4):485-496. doi: 10.18294/sc.2015.785

(PAHO) and the Economic Commission for Latin America (ECLAC) were incorporated in the research study. In total, 13 academic articles[3-15] issued by any of the above mentioned databases and 13 publications issued by international organizations[1,2,16-26] were selected. The bibliography was completed by adding specific documents used for giving specific definitions and examples.

In the statistical part, the report *Long-Term Care Resources and Utilisation Dataset* issued by the OECD Health Statistics was used.[27] This report provides annual information since 1980 for a total amount of 45 countries and two types of services: institutional services and home-based services. Institutional services provide both accommodation and long-term care. Hospitals are not included in this range of services. Home-based services allow beneficiaries to continue living in their own domiciles and services are provided in their own domicile and in adult day-care centers. Statistical sources do not show a disintegration of home-based services, nor do documents of international organizations. This is the reason why most of the articles that compare models between countries follow these same criteria.

LONG-TERM CARE

Long-term care is defined as the broad range of services and assistance for people who are limited in their ability to function independently on a daily basis,[16] that is, people with reduced ability to carry out basic activities of daily living (ADLs) – such as eating, having a shower or getting dressed – for a long period of time.[28-17] Long-term care services can be divided into six groups.

Firstly, the most traditional service is the residential care or long-term residential services, similar to the service offered by retirement homes in some countries. These facilities provide care and functional support 24 hours a day to dependent people suffering from complex health needs.[3] The OECD defines these health care centers as facilities which provide nursing and residential services and offer accommodation and long-term care as a complete care package.[17] Unlike domiciliary care, this service is provided at a center which is different from the dependent person's house. Generally, these people suffer from more complex health needs and a greater vulnerability, although this does not occur in all cases and countries.

Secondly, there is another type of service called domiciliary care and it includes visits of personnel qualified in health and social care. The aim of this service is to help the beneficiaries carry out the basic activities of daily living and to follow up their physical, mental and psychological health condition. The duration of the visit, frequency, and qualifications of the personnel are determined by the degree of severity of the person's dependency.

The third type of service is the service provided by adult day-care centers, which along with domiciliary care make up the home-based services. They owe their name to the fact that these centers allow dependent person to continue living in his or her domicile.[17] These centers do not have accommodation; however, most of them do have social workers as well as medical personnel, what implies a multidisciplinary perspective in health care. Adult day-care centers are designed for dependent people who live in their domiciles and who are generally unaccompanied during the day due to their relatives' working reasons. The features of these centers promote recovery, encouragement and development of dependent people's abilities.

The fourth type is not a service per se but it results in a service: financial aids for health care (cash-for-care). These financial aids consist of money transfers to dependent people, or their families, so that they will be able to satisfy health care needs in a direct way (people whose relatives take care of them) or through the hiring of external services.[18] When there is control over the hiring of formal services, it is usually known as "personal assistance" in order to differentiate it from domiciliary care.[4]

There is a fifth type that consists of services provided by distance support. These services consist of centers whose aim is to keep in touch with dependent people who are in their houses through a device which allows them to have a continuous connection by telephone or the Internet. The basic activities of the personnel are: to follow up the beneficiaries' proper compliance with the dosing schedule, to identify the risks of a health event, and, in a few cases, to provide support to dependent people in an informal and social way.

Finally, there is a sixth type of service which comprises prevention programs and promotion of autonomy programs. Sometimes, these programs

SALUD COLECTIVA. 2015;11(4):485-496. doi: 10.18294/sc.2015.785

are considered part of these policies. However, due to the extension of these programs in the public health framework, it is difficult to classify them as long-term care only.

Regarding these six types of services, there is some consensus in considering the first four services common to all or almost all long-term care policies. Most of the countries register certain information about the coverage, the formal workforce and the residential and home-based services. However, this information is heterogeneous and its availability varies from country to country. That is the reason why the statistical information used in the following sections does not keep the countries under investigation constant. Each analysis addresses as many countries as possible along with their statistical and academic available information. Germany, Korea, Denmark, Spain, the United States, France, Japan and Sweden have indicators for every aspect studied.

From informality to formality and *vice versa*

In the absence of long-term care public policies, the families, the market and the non-profit organizations assume the workload.[29] Some of the relationships that are established between these sectors are formal, but most of these relations are informal. Like an iceberg, only a small portion is visible above the surface.[1] Even in those countries where there are established models already, health care in the informal environment represents a 70 or 90 percent of the whole long-term care workload.[19]

This is the reason why one of the first differences between the models is how they relate to informality. Studies show that the percentage of people recognized to informally take care of a dependent person is 50% higher in countries such as Italy or Spain than in other countries such as Sweden or Denmark.[30] A similar result is obtained when calculating the number of formal workers in long-term care per thousand inhabitants (Figure 1). Among the countries which have a greater formality, Scandinavian countries stand out, along with the Netherlands and the United States. All these countries have values higher than 14 workers (per thousand inhabitants). On the opposite side, there are seven countries with values below five workers. Between these countries, there are recent models which have low coverage, like models from Portugal, Slovakia, Korea and the Czech Republic, but also France. In this case in particular, it has to be highlighted that the latest information available is from the year 2003 and that the beneficiaries of financial aids are not counted. Otherwise, the beneficiaries could have reached the total amount of 10.7% of people aged 65 years old and more. This can be argued in the French case due to the fact that this country has a control system in order to ensure that a big part of the hiring becomes formal hiring, something that does not happen in other cases such as the Italian and Spanish cases where there is freedom in expenditure and the amount of hiring is not registered.

The relationship between formality and informality is not a matter of black and white. When labor relationships in long-term care are analyzed, there appears a gradient of formality. This is known as labor *gray markets*.[6] On one side of this figure there is the Sweden model, which rests on formal care services, with formal hiring and qualified workforce. On the other side of this figure, there can be placed all countries which have underdeveloped or not developed systems, such as a few systems from Eastern Europe, in which families take care of elderly people for free. In the middle of these two opposite sides, formal models of long-term care appear, like the Italian model. These models, through their benefits, promote labor markets which are a little bit regulated, usually poorly qualified and have an important presence of immigrant workforce. Germany is also close to this model; however, when the size of this gray market is restricted, the participation of national work increases.

Coverage and services

The OECD has information about the coverage provided by each model according to the total amount of beneficiaries as proportion of the population aged 65 years old or more.[27] On the one hand, the results show that the highest values have been registered in Switzerland, the Netherlands and Scandinavian countries (Norway, Denmark and Sweden) which exceed 15% (Figure 2). On the other hand, the lowest values appear in Italy,

SALUD COLECTIVA. 2015;11(4):485-496. doi: 10.18294/sc.2015.785

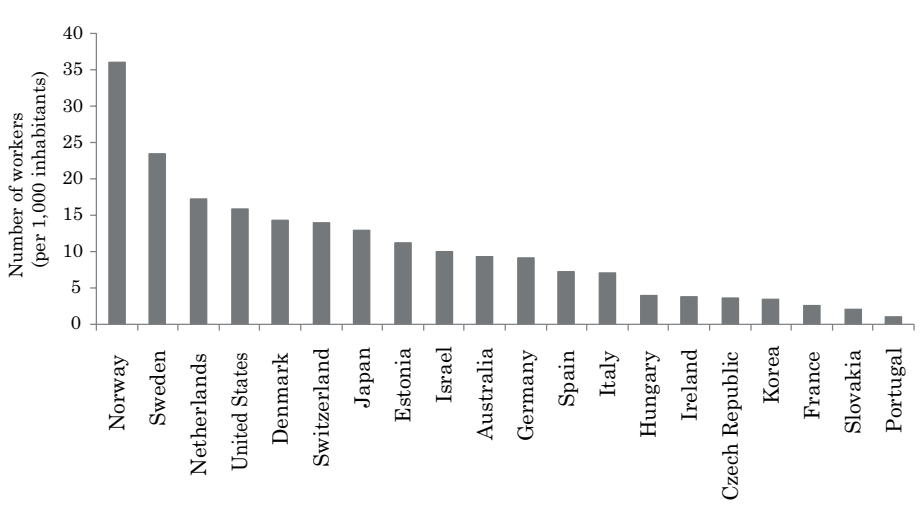

Figure 1. Formal workers in long-term care per thousand inhabitants, according to the countries selected, 2011.

Source: Own elaboration using data from Long-Term Care Resources and Utilisation dataset, Organisation for Economic Co-operation and Development (OECD); 2014.

Note: In those countries where no information was reported for the year 2011, information from the closest year was taken: Portugal, 2012; the Czech Republic and Denmark, 2009; Australia, 2007; and France and Italy, 2003.

Ireland, Canada, Slovakia and Poland which have values under 5%. In Italy, one of the reasons why the percentage is so low is the size of the population over 65 years old, the third greatest population of the OECD (20.4% of the population). But, principally, this percentage is so low due to the fact that there is no national program of care services apart from financial aids. The existing benefits are local and they vary according to territories and ages. This also occurs in Canada, where the responsibility and generosity of services depend exclusively on the provincial administrations. However, even if these financial aids and a few mixed care centers (residences and other services focused on medical care) are taken into consideration, the percentage will only increase up to a 4.5% in 2012. Therefore, these models can be identified as models of low coverage.

The coverage presented in Figure 2 belongs to the population that receives health care in residences or any formal home-based service, such as domiciliary care and adult day-care centers. In the cases where there is information available, it can be noticed that home-based services overtakes residential services, a logical fact due to the greater severity of dependency of the users of residential services. However, three groups of countries can be clearly identified according to the coverage offered to the population over 65 years old.[30] A first group (low-low) shows values under 2% for residential care and values under 5% for home-based services. Mostly, these are cases of countries from Eastern Europe and of Italy. A second group (medium-medium) oscillates between 4% and 10% respectively. Most of the countries from Continental Europe, the United Kingdom, Canada and the United States are included in this group. Finally, there is a third group (high-high) which registers rates of residential care close to 6% and, at the same time, a strong expansion in home-based services which reaches a 20%. These are the cases of Nordic countries, the Netherlands, Switzerland and Israel.

Models according to financial aids

Regarding financial aids, there are several studies which emphasize the wide variety of their formats and their increasing implementation in new and old models.[4,5,7,8,18]

SALUD COLECTIVA. 2015;11(4):485-496. doi: 10.18294/sc.2015.785

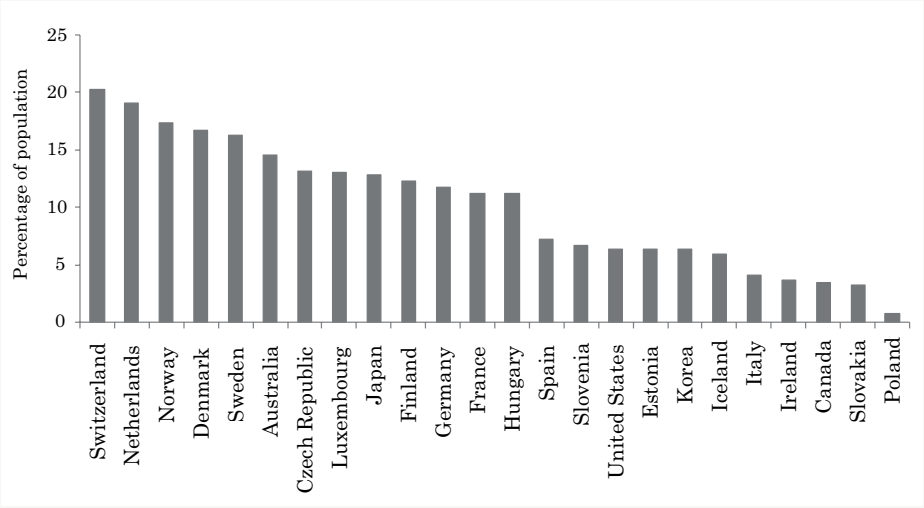

Figure 2. Percentage of the population that is 65 years old or more and that receives health care, according to the countries selected, 2011.

Source: Own elaboration using data from Long-Term Care Resources and Utilisation dataset, Organisation for Economic Co-operation and Development (OECD); 2014.

Note: In those countries where no information was reported for the year 2011, information from the closest year was taken: Canada, Iceland and France, 2010; the Czech Republic, 2009.

A service can be assigned or not according to the control over the kind of expenditure incurred by the beneficiary. For example, in Italy there is no control over the use of money, so that money can be used for family expenses, care expenses, or even leisure expenses. In Spain, the aid can be subject to the hiring of a formal service (a minority of cases) or health care within the family environment (this type of care is received by almost half of the system beneficiaries). In the latter case, it is expected that the caregiver contributes to social security, but it is not compulsory and less than 5% of caregivers do so. In other countries such as Denmark or Sweden, although these aids have been incorporated in the recent years, the granting of such aids is subject to formal hiring of specialized health care,[4] and, in Germany, although there is no control over this expenditure, the amount of money allows the family care to which that expenditure is intended to become a semiformal health care.[8]

Japan and France are two particular cases. In the case of Japan, voluntary health care of the so-called third age to the fourth age has been promoted. In two of its modalities a compensation – monetary or not – has been incorporated for caregivers; that is why it can be considered personal health care, although it is not a transfer like the rest. The second highlighted modality is the modality of France in which the financial aid is given by a sort of vouchers. Dependent people receive these vouchers or coupons and they can hire caregivers with them. The caregivers collect that payment in the city hall. In order to collect that money, caregivers must be registered as such and they must meet the requirements demanded by the administration, which allows the administration to control the caregivers' formation and to ensure the provision of the service.[5]

Models according to cost

The costs of models also vary. Available statistics of public spending show that the amount used for these models varies from values which are higher than 2% of the total amount of gross domestic product (GDP) in the Netherlands, Belgium and the group of Nordic countries, to values which are

SALUD COLECTIVA. 2015;11(4):485-496. doi: 10.18294/sc.2015.785

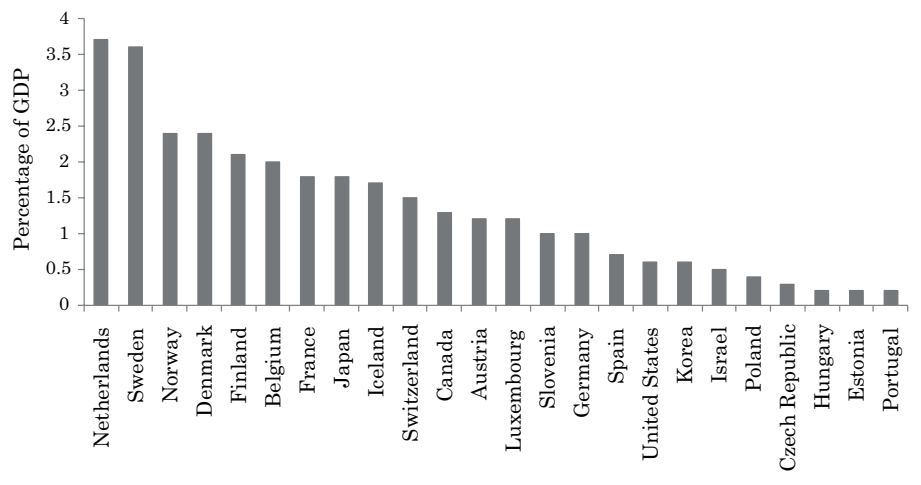

Figure 3. Public spending in long-term care as percentage of gross domestic product, according to the countries selected, 2011.

Source: Own elaboration using data from Long-Term Care Resources and Utilisation dataset, Organisation for Economic Co-operation and Development (OECD); 2014.

lower than 0.5% in Portugal and countries from Eastern Europe (Figure 3).

In this way, we can see a coincidence in the fact that countries having greater coverage, greater formality and more direct services are precisely the most expensive countries. This is the case of the Netherlands and the Scandinavian countries; Sweden, Norway and Denmark. However, as mentioned at the beginning of this article, in the case of the rest of the countries this relationship is not so clear.

Cost analysis is one of the most important items in the study of long-term care models, and for the purposes of this article, it is of crucial importance. It is logical to think that the larger the number of elderly people, the stronger the pressure for expanding the coverage and, therefore, the greater the tax effort. But the relationships between demand, financial aids and costs are a little bit more complex.

The increase of the amount of elderly people brings about an increase in the demand of long-term services.[31] The requests of benefits of long-term care services are greater if more people cross the barrier of 65 years old. Although there are several hypotheses[32] which show that the gained years of life expectancy will be lived without any dependency problem, there is little evidence that can support those hypotheses,[33] and definitely will not occur in the near future of Latin America.[20]

However, although aging of population is connected with the demand of services, this demand explains just a little about the increase of long-term care costs. Only 11.6% of the increase in health expenditure is due to demographic factors exclusively.[21] Social determinants, such as income or education, which are closely related to quality of life and health condition, are the factors that explain to a greater extent the costs of each system.[33] Regarding offer, prices, complexity of medical interventions and especially expansion of benefits are the main factors. Such is the case that, if the member countries of the OECD had maintained the same benefit levels between 1970 and 2002, their costs would have increased a quarter more of what they have actually increased.[34]

This expansion of benefits is precisely what determines if one model is more expensive than another model. Moreover, this expansion has not been linear, but it has been carried out by incorporating cheaper services.[9] Almost nine out of ten people responsible for long-term care policies point

SALUD COLECTIVA. 2015;11(4):485-496. doi: 10.18294/sc.2015.785

out that, at present, the main priority is tax and financial sustainability. That is why more than half of the countries have carried out several reforms in this field.

With these reforms, countries seek to expand home-based health care (adult day-care centers and domiciliary care) instead of residential care (which has practically not grown at all), and to incorporate or expand the benefits with right to financial aids instead of services. The cost of each of them is equally declining: in Spain, residential care is 2.5 times more expensive that domiciliary care, and, at the same time, domiciliary care is 2 times more expensive than the average amount of financial aid for family care.[35] In the United States, residential care can be two and five times more expensive than domiciliary services,[36] although there is no financial aid in this country. In Germany, few financial aids reach values which are close to a minimum wage, whereas in Denmark values are almost equivalent to the cost of domiciliary care.[8]

Although there is a criterion supporting this tendency of favoring that elderly people can actually age in their domiciles,[4] it is evident that cost restraints have played an important role in the service offer[9] given that it is not completely clear whether aging in the domicile is better for health care and caregivers or not.[10] The reason is that the increase of long-term care expenditure and their projections for future years is alarming: between 2005 and 2011 the expenditure of the OECD member countries has reached an annual average of 4.8% whereas their economies have grown merely 1.3%. This tendency would practically lead to a duplication of long-term care expenditure by 2060.[17,21]

Looking for the best model

It is admitted that some Nordic models have a wide coverage, services that encourage job formalization through home-based care, and restricted and controlled financial aids. These models are also the most expensive. Interestingly enough, differences are not so evident in the other cases. Germany offers a wider coverage of residential care and home-based services as compared with France. However, the GDP percentage figure for long-term care in France almost doubled the percentage of Germany's GDP.

Which model is more cost-efficient? It is hard to say. The demographic and health profiles of countries so distinct from each other such as Norway, the United States or Italy are different and affect the result. Even in cases where profiles are similar, it is difficult to isolate the variables and to define an indicator of quality of care or health output. A ray of light is shed on this issue when analyzing the users' perception of satisfaction.[30] Despite its limitations, self-perception is an approach to the satisfaction of needs adapted by expectations. In this sense, Scandinavian countries are placed above the other countries, but this time France and the Benelux countries (Belgium, the Netherlands and Luxembourg) are also in this position. That is to say, the French model, a model which does not reach the Nordic levels of coverage and expenditure and which is far from Nordic levels of residential care and home-based services, reaches degrees of satisfaction very similar to those from Nordic countries by incorporating financial aids with the voucher modality which make it possible to control the number of caregivers and their qualifications.[5] Models such as those from Austria, Germany or Spain are placed in a second position. A characteristic shared by these three countries is the fact that their rates of residential care and of home-based services are also lower than Nordic rates, although such rates are higher than the French rates. However, as opposed to France, these three countries incorporate an important dimension of financial aids over which no control is exercised about quality or training of caregivers. In the third group there are models whose offer of services is very limited. These models are criticized by beneficiaries due to the problems they have to get access to those models as well as their costs. This is the case of Italy, Portugal or Central Europe countries. Eastern Europe countries and the Balkans have worse valuations basically due to the fact that they do not have formal systems of long-term care.

What is the situation like in Latin America?

Different diagnoses show how Latin America is quickly getting closer to the aging levels seen in rich countries, when these rich countries had

SALUD COLECTIVA. 2015;11(4):485-496. doi: 10.18294/sc.2015.785

to introduce health care systems or reform the systems already in place.[11]

When comparing the evolution of elderly people over 65 years old in the overall population of some paradigmatic countries such as Denmark, France and Spain, two phenomena can be observed. Firstly, it can be seen that the speed of aging of Latin American population is more accelerated than the speed of aging of the countries above. Secondly, it can be noticed that Latin America will reach the current levels of the countries above in a little more than two decades.

This seems to give a relatively comfortable time frame for the government in the region and it is due to the fact that most countries still enjoy the presence of a demographic dividend.[22] This phenomenon appears when the relationship between working-age population and potentially dependent population (children and elderly people) reaches its highest values; that is to say, when there is a reduction in the birth rate, which in turn reduces the workload in the care of minors and the adult population is still far from reaching old age. This period ends when that adult population is out of the labor market and reaches age levels where health condition gets worse. The turning point will occur in some twenty years later, when the fall of the percentage of people under 15 years of age will intercept the increase of people aged 65.[23]

However, this temporary relief of demographic dividend does not affect every country in the same way. There are a few countries which are in the last stage such as Chile, Brazil and Costa Rica.[22] In an analysis about pressures of supply and demand of dependent elderly people care, Argentina and Uruguay are added in that category as countries which have the highest emergence in the implementation of long-term care solutions.[11] In fact, when considering only the percentage of population over 65 years old, it can be noticed that in 2013 Uruguay almost doubled the rate of the region (14.1% and 7.2% respectively), followed by Chile and Argentina (11% and 10% respectively).

These five countries have not reached these levels of aging with the same wealth levels as more developed countries have, and the rest of the region seems to be unlikely to reach those levels.[12] Moreover, health studies seem to show that the population of the region will reach adult age with more health problems due to the fact that its increase on life expectancy is principally a result of health interventions and medical innovations than of higher standards of life or a better nutrition.[13] Proof of this is the fact that adult people from Latin America show serious problems of obesity, cholesterol, hypertension and arthritis.[20,14] All these problems will increase the risks of having a deteriorated old age and will increase the demand of long-term care services.

There is a certain degree of coincidence in the fact that the social security systems in the region do not seem to be prepared to face this challenge.[23,12] Although a few countries report having universal coverage systems, the truth is that their low levels of public spending and their high out-of-pocket expenditure do not stay in line with this statement.[24]

When analyzing country by country, it can be noticed that only six out of thirteen countries have some type of home-based system or specialized center[25] and four of them coincide with those identified as having the highest emergence: Argentina, Chile, Costa Rica and Uruguay; however, the coverage of that countries is still very limited. Cost is one of the main issues of concern. If current health benefits are kept, only the increase of the number of elderly people could raise the public spending up to approximately one percent point of the GDP in the next thirty years. But if health demands are faced in a way which is similar to the way of the OECD member countries, this increase could be fourfold.[26]

The estimations of long-term care models of domiciliary care calculate an expected cost which can reach almost 15,000 annual dollars per capita in Argentina and a little more than 11,000 annual dollars in Mexico.[37] An exclusive system of domiciliary care for people who are in a more serious situation in Chile would cost 3,600 annual dollars per dependent person.[38] This would increase the budget up to more than one percent point of the GDP, which is similar to other countries with more developed systems such as Austria or Canada. The reason for this is that in the quoted studies the hours of health care have been overestimated, especially in serious dependent people. If averages more similar to those of the Mediterranean European models were considered, the annual cost would fall; for example, in the case of Chile the annual cost would fall to a little more than 4,000 dollars per capita, which is equivalent to almost 0.5% of the GDP.[15] Anyway,

SALUD COLECTIVA. 2015;11(4):485-496. doi: 10.18294/sc.2015.785

this represents a significant tax effort in countries which have limited budgetary margins.

CONCLUSIONS AND PROPOSALS

Latin America took more than half a century to double the percentage of people over 65 years old. However, now it will take a little more than two decades to repeat this phenomenon. By the middle of this century, one out of five people will be that age or more. This is a phenomenon that has already taken place in past decades in rich countries. In the last thirty years, these countries have planned, implemented and reformed their health policies many times in order to face the problem of elderly people dependency. Now, it is Latin America's turn.

The region moves quickly towards the issues of aging and dependency of elderly people, but its social and health systems are not so prepared to face this reality. It is estimated that the time frame to react is just a little more than two decades for most of the countries. But this does not occur in countries like Argentina, Brazil, Chile, Costa Rica and Uruguay, where the demographic dividend is in its last stage.

Thanks to the analysis of existing models it is possible to differentiate countries from Northern Europe such as Sweden, Norway, Denmark and the Netherlands from the rest of the countries. The above mentioned countries have Welfare States financed by a strong tax burden, which allows these countries to offer health care models based on formal provision of residential care and home-based services, with a wide coverage and a minimum co-payment. However, this has not stopped countries from making efforts to restrain costs. This is the reason why measures of private administration have been taken in public administration, doors have been opened to private provision and a few financial aids have been incorporated. In the case of the rest of the countries, the search for balance between the pressure of the rising costs and the increase of the demand has been tackled with a wave of reforms in two directions. The first direction is an expansion of the coverage of their home-based care systems (adult day-care centers and domiciliary care) more than in the residential care systems. The second direction is the incorporation, in almost all of the countries, of financial aids with a wide coverage for direct hiring of services by the dependent people or their families.

What has Latin America learnt from this? In general, Latin America has learnt that the higher the definition of the coverage, the greater the demand of services. And this is a decisive issue as, unlike most of the analyzed countries, the countries in this region have less economic resources and these resources are not expected to grow extraordinarily in the next years. Therefore, it is interesting and useful to consider these latest reforms more in depth.

Models grounded on home-based services do not have a budgetary impact as high as residential services have and they can be very useful in most of the cases in which the severity of the dependency is not so high. In the same way, financial aids can be a useful tool and can offer a quick response when sufficient resources and infrastructure are not available.

However, as shown by the experiences analyzed in this article, not having any home-based service is good and not having any financial aid is useful. Aging in one's home can end up worsening dependent people's lives or the lives of the relatives living with them if it is not a sociosanitary efficient health care option or if it is not accompanied by a sociosanitary efficient health care. Adult day-care centers and home-based services are not effective by themselves but they are affected by the intensity and quality of the health care provided. That is why adult day-care centers and home-based services must have sufficient budget and must include qualified personnel for the services provided. These services cannot be exclusively subject to the cost reduction criterion.

Moreover, granting financial aids without exercising any control over the expenditure or over the qualification of caregivers can end up with an institutionalization of low quality informal care and with a precarization of the dependent person's life as well as the caregiver's life. Not all tools provide the same results and not all tools are used in the same way.

In conclusion, it is necessary to move forward in this field, to address the health and medical response capacity of the countries in the region and to start evaluating different types of long-term care models appropriate for this context in particular.

SALUD COLECTIVA. 2015;11(4):485-496. doi: 10.18294/sc.2015.785

REFERENCES

1. Organisation for Economic Co-operation and Development. Help wanted?: providing and paying for long-term care [Internet]. Paris: OECD Publishing; 2011 [cited 10 Jan 2015]. Available from: http://goo.gl/QzDyFp.

2. Pacolet J, Bouten R, Lanoye H, Versieck K. Social protection for dependency in old age: A study of the 15 EU member states and Norway [Internet]. European Commission; 1999 [cited 10 Jan 2015]. Available from: http://goo.gl/d3u6UM.

3. Sanford AM, Orrell M, Tolson D, et al. An international definition for "Nursing home". Journal of the American Medical Directors Association. 2015;16(3):181-184.

4. Askheim OP, Bengtsson H, Richter BR. Personal assistance in a scandinavian context: Similarities, differences and developmental traits. Scandinavian Journal of Disability Research. 2014;16:3-18.

5. Da Roit B, Le Bihan B. Similar and yet so different: Cash-for-care in six European countries' long-term care policies. Milbank Q. 2010;88(3):309.

6. Simonazzi A. Care regimes and national employment models. Cambridge Journal of Economics. 2009;33(2):211-232.

7. Hayashi M. Japan's long-term care policy for older people: The emergence of innovative "mobilisation" initiatives following the 2005 reforms. Journal of Aging Studies. 2015;33:11-21.

8. Frericks P, Jensen PH, Pfau-Effinger B. Social rights and employment rights related to family care: Family care regimes in Europe. Journal of Aging Studies. 2014;29:66-77.

9. Swartz K. Searching for a balance of responsibilities: OECD countries' changing elderly assistance policies. Annual Review of Public Health. 2013;34:397-412.

10. Maruyama S. The effect of coresidence on parental health in Japan. Journal of the Japanese and International Economies. 2015;35:1-22.

11. Matus M, Rodriguez P. Presiones de oferta y demanda sobre políticas formales de cuidados en Latinoamérica. Revista del CLAD Reforma y Democracia. 2014;60:103-130.

12. Palloni A, McEniry M. Aging and health status of elderly in Latin America and the Caribbean: Preliminary findings. Journal of Cross-Cultural Gerontology. 2007;22(3):263-285.

13. Palloni A, McEniry M, Wong R, Pelaez M. The tide to come: Elderly health in Latin America and the Caribbean. Journal of Aging Health. 2006;18(2):180-206.

14. Al Snih S, Graham JE, Kuo YF, Goodwin JS, Markides KS, Ottenbacher KJ. Obesity and disability: Relation among older adults living in Latin America and the Caribbean. American Journal of Epidemiology. 2010;171(12):1282-1288.

15. Matus-López M, Cid Pedraza C. Costo de un sistema de atención de adultos mayores dependientes en Chile, 2012-2020. Revista Panamericana de Salud Pública. 2014;36(1):31-36.

16. European Commission. The 2012 ageing report: Economic and budgetary projections for the 27 EU member states [Internet]. Brussels: Economic Policy Committee; 2012 [cited 10 Jan 2015]. Available from: http://goo.gl/hlHD6X.

17. Organisation for Economic Co-operation and Development. Health at a glance 2013 [Internet]. OECD; 2013 [cited 10 Jan 2015]. Available from: http://goo.gl/G5IkCU.

18. Bettio F, Verashchagina A. Long-term care for the elderly: Provisions and providers in 33 European countries [Internet]. European Commission; 2010 [cited 10 Jan 2015]. Available from: http://bit.ly/1JJV1ch.

19. Fujisawa R, Colombo F. The long-term care workforce: Overview and strategies to adapt supply to a growing demand (OECD Health Working Papers No. 4) [Internet]. 2009 [cited 10 Jan 2015]. Available from: http://bit.ly/1JJWkbo.

20. Medici A. How age influences the demand for health care in Latin America. In: Cotlear D, editor. Population aging: Is Latin America ready? [Internet]. Washington DC: World Bank; 2011 [cited 10 Jan 2015]. Available from: http://bit.ly/1j81RiH.

21. Maisonneuve C, Oliveira J. Public spending on health and long-term care: A new set of projections (OECD Economic Policy Papers No. 6) [Internet]. 2013 [cited 10 Jan 2015]. Available from: http://bit.ly/1JJYyr5.

22. Saad P. Demographic trends in Latin America and the Caribbean. In: Cotlear D, editor. Population aging: Is Latin America ready? [Internet]. Washington DC: World Bank; 2011 [cited 10 Jan 2015]. Available from: http://bit.ly/1j81RiH.

23. Huenchuan S. Ageing, solidarity and social protection in Latin America and the Caribbean: Time for progress towards equality [Internet]. San-

SALUD COLECTIVA. 2015;11(4):485-496. doi: 10.18294/sc.2015.785

tiago: ECLAC; 2013 [cited 10 Jan 2015]. Available from: http://bit.ly/1EEUoRm.

24. Suarez-Bereguela R, Vigil-Oliver W. Health care expenditure and financing in Latin America and the Caribbean [Internet]. Washington DC: Pan American Health Organization; 2012 [cited 12 Jan 2015]. Available from: http://bit.ly/1FJOw5v.

25. Comisión Económica para América Latina y el Caribe. Panorama social de América Latina 2012 [Internet]. Santiago: CEPAL; 2012 [cited 12 Jan 2015]. Available from: http://goo.gl/VSXcCt.

26. Miller TC, Mason C, Holz M. The fiscal impact of demographic change in 10 Latin American countries: Projecting public expenditures in education, health and pensions. In: Cotlear D, editor. Population aging: Is Latin America ready? [Internet]. Washington DC: World Bank; 2011 [cited 10 Jan 2015]. Available from: http://bit.ly/1j81RiH.

27. Organisation for Economic Co-operation and Development. Health statistics 2014 [Internet]. OECD.Stat 2015 [cited 8 Jan 2015]. Available from: http://bit.ly/1qtVKpJ.

28. World Health Organization. A glossary of terms for community health care and services for older persons [Internet]. Aging and health technical report No. 5; 2004 [cited 8 Jan 2015]. Available from: http://bit.ly/1OaOmsp.

29. Razavi S. The political and social economy of care in a development context: Conceptual issues, research questions and policy options [Internet]. Geneva: UNRISD; 2007 [cited 10 Jan 2015]. Available from: http://goo.gl/zb62EU.

30. Carrera F, Pavolini E, Ranci C, Sabbatini A. Long-term care systems in comparative perspective: Care needs, informal and formal coverage, and social impacts in European countries. In: Ranci C, Pavolini E, editors. Reforms in long-term care policies in Europe. New York: Springer; 2013. p. 23-52.

31. Bonneux L, Van der Gaag N, Bijwaart G. Demographic epidemiologic projections of long-term care needs in selected European countries: Germany, Spain, the Netherlands and Poland. ENEPRI Research Report No. 8 [Internet]. 2012 [cited 10 Jan 2015]. Available from: http://bit.ly/1zg1OUS.

32. Manton K. The dynamics of population aging: Demography and policy analysis. Milbank Q. 1991;69(2):309-338.

33. Kinsella K, He W. An ageing world: 2008 [Internet]. Washington DC: U.S. Government Printing Office; 2009 [cited 10 Jan 2015]. Available from: http://1.usa.gov/1Hrlf49.

34. Hagist C, Kotlikoff L. Who's going broke? comparing growth in healthcare costs in ten OECD countries. NBER Working Paper No. 11833 [Internet]. 2005 [cited 10 Jan 2015]. Available from: http://bit.ly/1E1G8U3.

35. Prada MD, Borge LM. Una aproximación al coste de la dependencia en España y su financiación [Internet]. Madrid: Fundación CASER; 2014 [cited 10 Jan 2015]. Available from: http://goo.gl/h16P6f.

36. Genworth. Cost of Care Survey 2015 [Internet]. 2015 [cited 10 Apr 2015]. Available from: http://bit.ly/1GJWdOD.

37. Monteverde M, Noronha K, Palloni A, Ageletti K. Costos individuales esperados de cuidados de larga duración en Buenos Aires, México y Puerto Rico. In: Peláez E, editor. Sociedad y adulto mayor en América Latina: Estudios sobre envejecimiento en la región. Córdoba: Editorial Copiar; 2008.

38. Matus-López M, Cid C. Costo de un sistema de atención de adultos mayores dependientes en Chile, 2012-2020. Revista Panamericana de Salud Pública. 2014;36(1):31-36.

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